



# Idaho Department of Juvenile Corrections

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C.L. "BUTCH" OTTER  
Governor

LARRY W. CALLICUTT  
Director

## MEMORANDUM

To: Department of Health and Welfare  
Detention Facility Administrators

Idaho Juvenile Justice Commission  
Legislators

From: Larry W. Callicutt, Director

Date: February 11, 2009

Subject: Detention Clinician Project Research Findings

Based upon a successful pilot project initiated by the Juvenile Justice Children's Mental Health Workgroup (JJCMH) in the Bonneville County (3-B) detention facility; the Idaho state legislature appropriated funding to the Idaho Department of Juvenile Corrections (IDJC) to support clinicians in all 12 county detention facilities.

In FY08, IDJC was allocated \$522,000 in funding for the program. IDHW invested an additional \$50,000 and the Idaho Juvenile Justice Commission made \$125,000 available to ensure rural areas would be adequately served.

Dr. Tedd McDonald from the Boise State University Center for Health Policy analyzed the data entered by clinicians into a database, surveyed stakeholders, and completed an evaluation which is attached. Over 2,060 juveniles were booked into detention facilities and were the basis for initial research on the effectiveness of this program. Some highlights from the evaluation include:

- Mental health and substance abuse problems appear very common among juveniles in juvenile detention facilities with over 84% having a diagnosable mental illness, substance abuse issue or both.
- Juveniles having both a mental health and substance abuse issue together typify the largest population of juveniles entering detention facilities.
- Over 40% of the juveniles entering detention facilities in Idaho have co-occurring disorders (mental health and substance abuse). Conversely, only 17% of the juveniles entering detention facilities have neither a mental health nor a substance abuse issues.
- Over 20% of the juveniles screened were found to have mental health issues that previously were unknown.

*An active partnership with communities*

- Over 50% of the juveniles who were recommended services in the community accessed those services within 2 weeks.
- The extremely high incidence of mental illness and substance abuse for juveniles entering detention facilities indicates clinicians in detention facilities are essential to maintain safety within facilities, determine appropriate care and make referrals to community-based treatment services.
- Juveniles and their families seem motivated to access community services.
- To divert juveniles from deeper involvement in the juvenile justice system, a network of co-occurring capable providers is essential for appropriate treatment in the community.

The research report is also posted on the IDJC web site and can be downloaded by going to <http://www.idjc.idaho.gov/> and clicking on the Grants and Grant Forms link.

LWC:DW

**A Statewide and Multimodal Assessment of the  
Idaho Department of Juvenile Corrections' Clinical Services Program**

Prepared for the Idaho Department of Juvenile Corrections

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## Executive Summary

During 2007, a pilot program was established that housed, for the first time, an on-site mental health clinician in one of the 12 juvenile detention centers (JDCs) in Idaho. This clinician worked with juveniles detained in the JDC in Bonneville County, and a principal component of his work was to screen detained juveniles for mental health and substance abuse problems, and to make provisional diagnoses of these problems when warranted. The clinician also recommended services in the community for juveniles with provisionally diagnosed mental health or substance abuse problems when they were released into the community. An internal evaluation of this program suggested that it was successful in identifying mental health and substance abuse problems (83% of the screened juveniles were provisionally diagnosed with a mental health problem, a substance abuse problem, or both) and in linking juveniles with these problems with community-based services upon release. Some preliminary data also suggested that the resources provided by the clinician helped reduce future recidivism (as measured by subsequent bookings of previously detained juveniles) and reduced problem behavior (most notably assaults) in the Bonneville County JDC. The project appeared well received by judges and juvenile probation officers in eastern Idaho, both of whom received contact and recommendations from the clinicians as they worked with juveniles from the JDC; 100% of these law enforcement personnel who completed a survey on the pilot project recommended that it continue.

The pilot project appeared so successful that it was expanded in 2008 to all 12 JDCs in Idaho; in addition to the JDC in Bonneville County, clinicians were hired to serve in the JDCs in Ada, Bannock, Bonner, Canyon, Fremont, Kootenai, Lemhi, Minidoka, Nez Perce, Twin Falls, and Valley counties. This expanded clinical services project was conducted as a partnership among the Idaho Department of Juvenile Corrections (IDJC), the Juvenile Justice Children's Mental Health Workgroup (JJCMH), and the Idaho Department of Health and Welfare (IDHW). IDJC, which was responsible for oversight of the project, contracted with researchers from the Center for Health Policy at Boise State University (BSU), to evaluate the expanded project. The evaluation consisted of data collected in three waves. The first wave involved the collection of data from clinicians at the JDCs; this information included booking charges, mental health and substance abuse screening information, information on previous and provisional diagnoses of mental health and substance abuse problems, and information on service recommendations made by the clinicians. The second wave of data collection involved information gleaned from surveys that were mailed to parents of juveniles recently released from the JDCs; these surveys asked questions about whether the parents had been contacted by clinicians and given recommendations for services for their children, and whether their children had accessed any recommended services. The third wave of data collection involved information captured from surveys of judges and juvenile probation officers, which asked questions about contact by JDC clinicians, the value of recommendations made and information provided, and the value of the program as a whole.

Key findings from each of the three waves of data collection are presented below.

### **JDC Clinician Data:**

- **Data were submitted on a total of 2,060 juveniles**
  - **Over 70% of the juveniles on whom data were collected were boys, and less than 30% were girls**
  - **Usable data on detained juveniles were submitted by clinicians at 11 of the 12 JDCs across the state (no data were submitted from the JDC in Lemhi County)**
  - **The JDCs that submitted the most data cases included those in Kootenai, Twin Falls, and Bannock counties (the JDC in Kootenai County alone submitted almost 27% of the total cases in the study). The JDCs that submitted the fewest data cases included those in Valley, Canyon, and Fremont counties**
- **The most common booking charges for juveniles across all 11 JDCs were “Other crimes” not easily fitting one of the four Uniform Crime Recording codes, drug crimes, property crimes, and crimes against persons.**
- **More than 68% of all juveniles screened with the Alaska Screening Tool’s (AST) mental health and substance abuse subscales met the diagnostic criteria for having a mental health problem**
  - **Girls (at over 76%) were statistically significantly more likely to meet the AST criteria for a mental health problem than were boys (65%)**
  - **Juveniles met the AST criteria for having a mental health problem at statistically significantly different rates across the 11 JDCs**
    - **Indications of mental health problems were highest among juveniles screened at the JDCs in Canyon (100%), Bonner (86%), and Fremont (80%) counties. Indications of mental health problems were lowest among juveniles screened at the JDCs in Valley (53%), Bannock (53%), and Minidoka (62%) counties**
- **Nearly 55% of all juveniles screened with the AST met the diagnostic criteria for having a substance abuse problem**
  - **Boys and girls met the AST criteria for having a substance abuse problem at similar rates**
  - **Juveniles met the AST criteria for having a substance abuse problem at statistically significantly different rates across the 11 JDCs**
    - **Indications of substance abuse problems were highest among juveniles screened at the JDCs in Nez Perce (72%), Bonner (69%), and Canyon (68%) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Minidoka (31%), Bonneville (42%), and Valley (47%) counties**
- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that 82% of all screened juveniles had a mental health problem, a substance abuse problem, or both**
  - **Having indications for both a mental health and substance abuse problem was the most common single combination (at 41%), followed by having a mental health**

problem only (28%), having neither a mental health nor a substance abuse problem (18%), and having a substance abuse problem only (14%)

- A statistically significant difference existed in combination of mental health and substance abuse indications between boys and girls. Whereas boys were more likely than girls to have indications of neither a mental health nor a substance abuse problem (19% to 15%) and a substance abuse problem only (16% to 9%), girls were more likely than boys to have indications of a mental health problem only (32% to 26%) and both a mental health and substance abuse problem (44% to 39%)
- A statistically significant difference also existed in combination of mental health and substance abuse indications as a function of JDC location
  - Whereas the most common single combination of indications for juveniles in nine JDCs was having both a mental health and a substance abuse problem, the most common combination in the Bonneville County JDC was having a mental health problem only, and the most common combination in the Minidoka County JDC was having neither a mental health problem nor a substance abuse problem.
  - Whereas the least common single combination of indications for juveniles in nine JDCs was having a substance abuse problem only, the least common combination in the JDCs in Nez Perce and Twin Falls counties was having neither a mental health nor a substance abuse problem
- Nearly 60% of the juveniles across all JDCs reported during a clinical interview that they had been diagnosed previously with at least one mental health or substance abuse problem. The mean number of previous diagnoses for previously diagnosed juveniles was 1.26
  - Boys and girls reported similar mean numbers of previous diagnoses (1.26 and 1.24, respectively)
  - A statistically significant difference in mean number of previous diagnoses was found as a function of JDC location
    - Mean numbers of previous diagnoses were highest among juveniles in the JDCs in Ada (1.55), Nez Perce (1.51), and Fremont (1.50) counties. Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Bonneville (1.08), Valley (1.09), and Kootenai (1.10) counties
- Nearly 84% of juveniles who were screened with the AST and completed a clinical interview were given at least one provisional diagnosis of a mental health or substance abuse disorder. The mean number of provisional diagnoses for all juveniles with at least one provisional diagnosis was 1.56
  - A statistically significant difference in mean number of provisional diagnoses given was found between boys and girls. Girls were given more provisional diagnoses (1.62) of mental health or substance abuse problems than were boys (1.53)
  - A statistically significant difference in mean number of provisional diagnoses given was also found as a function of JDC location
    - The highest mean numbers of provisional diagnoses given were to juveniles in the JDCs in Nez Perce (2.30), Bonner (2.02), and Ada (1.97) counties. The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Kootenai (1.10), Bannock (1.20), and Minidoka (1.28) counties

- The most commonly given provisional diagnosis was for a mood disorder, which appeared to affect just over half of the provisionally diagnosed juveniles. Other common provisional diagnoses included substance abuse disorders (40% of those provisionally diagnosed), disruptive behavior disorders (32%), anxiety disorders (16%), and attention deficit disorders (10%)
- Recommendations for at least one service in the community were made for 1,523 juveniles, or nearly 90% of those juveniles who received a provisional diagnosis. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.77
  - The difference in mean number of recommendations for services was found to be statistically significant between boys and girls. Girls were given significantly more service recommendations (1.95) than boys (1.68)
  - There was also a difference in the mean numbers of recommendations for services as a function of JDC location
    - The highest mean numbers of recommended services were given to juveniles in the JDCs in Bonner (2.26), Twin Falls (2.23), and Canyon (2.10) counties. The lowest mean numbers of recommended services were given to juveniles in the JDCs in Ada (1.30), Bonneville (1.33), and Nez Perce (1.58) counties
- The most commonly given recommendation for services was a recommendation for individual counseling (70% of juveniles who were given at least one service recommendation received a recommendation for counseling). Other commonly received service recommendations were for a psychological/mental evaluation (36%), substance abuse counseling/treatment (32%), substance abuse assessment (10%), and family counseling (9%)
- According to information gained by clinicians during a 15-day post-release follow-up call, 810 juveniles, or 53.2% of those who received at least one recommendation for a service, had accessed at least one recommended service. The mean number of accessed recommended services among juveniles who received at least one recommendation was .86
  - No statistically significant difference in mean number of recommended services accessed was found between boys (.84) and girls (.88)
  - A statistically significant difference in mean numbers of recommended services accessed was found as a function of JDC location
    - The highest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Twin Falls (1.16), Bannock (1.11), and Kootenai (1.05) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Minidoka (.01), Canyon (.15), and Ada (.31) counties

#### **Parent Survey Data:**

- The response rate to the parent survey was very low at 5.4%, as only 48 parents out of 888 who were sent a survey mailed a survey back to the researchers at BSU
  - Because the response rate was so low, caution should be used when generalizing the responses of the parents who responded to all parents of recently released juveniles

- Nearly 45% of the parents who returned a survey reported that they had been contacted by the JDC clinician and informed that their child had been identified as a person who could benefit from community-based mental health and/or substance abuse services
- Of the parents who reported being informed that their child had been identified as someone who could benefit from services, 95% reported that they were given recommendations for community-based services for their child
- The services parents most often reported their children being recommended included mental health evaluation/treatment (41%), substance abuse treatment/support groups (29%), and family services programs/organizations (24%)
- Only three parents reported barriers to their children accessing the services they were recommended. Two of these reported that their child refused to access the service, and the third reported not being able to afford the recommended service

#### **Judge/Juvenile Probation Officer Survey**

- The response rate to the survey sent to judges/juvenile probation officers was much higher than that for the parent survey, at 44.3%, as 50 of the 113 judges/juvenile probation officers who were sent a survey returned a survey
- Nearly two-thirds of the judges/juvenile probation officers who completed a survey reported that they were aware that the JDC nearest to them had a mental health clinician working in it
- Of the judges/juvenile probation officers who were aware of the clinical services program, nearly 80% reported having been contacted by a clinician regarding one of the youth they were working with
  - Levels of satisfaction with the contact from the JDC clinicians were very high, as nearly 90% of those judges/juvenile probation officers who reported having been contacted were very satisfied (50%) or satisfied (39%) with the contact
- Of the judges/juvenile probation officers who had been contacted by a JDC clinician, 93% reported having been given a recommendation on treatment or decisions from this clinician
  - Levels of satisfaction with recommendations provided by the JDC clinicians were high, as nearly 80% of those judges/juvenile probation officers who reported receiving at least one recommendation were satisfied (46%) or very satisfied (33%) with the recommendation(s)
- Among the judges/juvenile probation officers who reported having received recommendations from the clinicians, nearly three-fourths reported that the recommendation they received affected a decision or treatment advised for the youth

- **When asked to judge how beneficial the clinical services program was, the most common response made by the judges/juvenile probation officers was “extremely beneficial” (nearly 60%), followed by “rather beneficial” (19%). Only 11% reported the program as being “not at all beneficial” (7%) or “not very beneficial” (4%)**
- **When asked whether they would like to see the clinician program continue, 92% of the judges/juvenile probation officers reported wishing to see it continue**

## Overview

In August 2006, the Idaho Department of Health and Welfare (IDHW) provided funds to initiate a project housing a mental health clinician in the juvenile detention center (JDC) in Bonneville County (known in the Idaho juvenile correction community as the “3B Detention Center”). Prior to this time, no JDCs in Idaho had a clinician working in them, and this hiring was part of a pilot program to determine whether having a clinician in a JDC would have beneficial impacts on detained youth (e.g., through facilitating mental health or substance abuse treatment in the JDC or referral to community-based services upon release from the JDC), as well as desirable institutional (e.g., fewer behavior problems in the JDC) and social (e.g., lower rates of recidivism) outcomes. An additional purpose of the project was to allow the hired clinician, Mr. Brian Mecham, a licensed clinical social worker affiliated with Behavior Consultation Services, to collect some baseline information on the prevalence of mental health and substance abuse problems among detained youth in Idaho.

The pilot program was conducted for 14 months, and concluded in October 2006. Mr. Mecham issued an internal report describing his activities and providing some preliminary results of the project. In this report, Mecham described his screening of youth for mental health and substance abuse problems, and how he initially tried three different standardized screening tools, before settling on the use of the Alaska Screening Tool (AST) after finding it the most reliable. He also described how provisional diagnoses of mental health or substance abuse problems were made, based on both AST screening and a brief clinical interview. Furthermore, he described how a treatment plan was formulated, and how, upon the release of each provisionally diagnosed juvenile, contacts were made with both parents and juvenile probation officer (if the juvenile had one) to facilitate access to community-based services that he recommended for the released juvenile. Finally, Mr. Mecham described the survey he conducted of judges and juvenile probation officers to assess the extent to which they found the pilot program beneficial in terms of informing or impacting their law enforcement decisions or treatment requirements for detained juveniles.

In his report, Mr. Mecham noted that fully 83% of the 335 juveniles he screened were given a provisional diagnosis of a mental health or substance abuse disorder, and that 37% of all screened youth were given a provisional diagnosis for both a mental health and a substance abuse disorder (often referred to in the clinical community, as well as his report, as “a dual diagnosis”). He also noted that, through his follow up contact with juveniles, parents, and/or juvenile probation officers, it appeared that approximately 41% of the juveniles who were released with recommendations for community-based services accessed at least some of those services. Using preliminary data, he reported that the recidivism rate at the Bonneville County JDC appeared to be lower (with 176 juveniles being booked in the JDC at least twice) during the year the program was in place than the previous year when the program was not in place (when 199 juveniles were booked in the JDC at least twice). He also reported that during the year the pilot program was in place, the number of assaults was substantially lower (at six) than the previous year that the program was not in place (when 11 assaults were documented). Finally, he reported that, based on the results of the judges/juvenile probation officer survey, these law enforcement personnel were highly supportive of the pilot program—as 100% of those who completed the survey reported that clinician recommendations affected decisions they made regarding the youth, and 100% reported that the program is beneficial to the community, and that they would like to see it continue.

Based on the positive results of the pilot program at the Bonneville County JDC, the program was expanded, with joint participation from IDJC, IDHW, and the Juvenile Justice Children’s Mental

Health Workgroup (JJCMH), to 11 other JDCs throughout Idaho. These JDCs included those in Ada, Bannock, Bonner, Canyon, Fremont, Kootenai, Lemhi, Minidoka, Nez Perce, Twin Falls, and Valley counties. Clinicians began to be hired and trained in December 2007, and this process continued throughout early 2008. IDJC contracted with researchers at the Center for Health Policy at Boise State University (BSU) to conduct an external evaluation of the expanded program between January 1, 2008 and December 31, 2008. This report describes the expanded program, the data collected in the evaluation, and the results of the evaluation and their implications.

## Methodology

Data was collected in three separate waves in this evaluation project. The first wave involved personnel at IDJC collecting data directly from clinicians at the JDCs and, after stripping all personally identifying information, providing the data to the researchers at BSU. The second wave involved surveys being mailed from the clinicians at the JDCs to parents of recently released juveniles. The third wave involved surveys being mailed from the researchers at BSU to judges/juvenile probation officers who worked with juveniles recently released from the JDCs. As is discussed below, some of the data collection processes were similar to what had been used in the evaluation of the pilot project at the JDC in Bonneville County, and some elements of the data collection processes were new to this expanded project. Each wave will be discussed sequentially.

### Wave One: JDC Data

The first wave of data collection involved collecting information on detained juveniles directly from clinicians at the JDCs. When juveniles are detained at a JDC, a variety of information about them is collected at intake. A portion of this information was use for analytical purposes in the pilot project at the JDC in Bonneville County, and the same information was used in this evaluation. Each individual piece of information is described below.

*Juvenile ID:* A unique ID number is assigned to each juvenile when he or she is detained in a JDC. These numbers are not linked in any meaningful way to juveniles (e.g., they are not the juveniles' social security numbers, birth dates, ect.), so providing them to the BSU researchers did not violate any confidentiality protections. The real value of the Juvenile ID numbers was twofold. First, having the ID code allowed the researchers to determine when juveniles had been booked multiple times (it was clear when juveniles had been booked several times during the study period, as the ID code appeared twice in the database). Second, the booking number was preceded by a two-letter code indicating what county JDC they had been detained in (for example, the two-letter code "1A" indicated that a juvenile had been detained in the Ada County JDC), which allowed for appropriate categorizing of the data for comparisons among JDCs.

*Gender:* All data was coded by the gender of the detained juvenile. This information was used for demographic purposes (to describe the gender distribution of the detained juveniles) and for analytical purposes (to compare important outcome variables, such as mental health and substance abuse diagnoses, as a function of gender).

*Booking Charge(s):* The booking charge or charges for all juveniles were typed into the database by clinicians. Up to four separate booking charges could be coded through a content analysis procedure aggregating conceptually similar booking charges into common themes (for example, combining "vandalism", "destruction of property", and "theft" into a larger category of "Property Crimes") and entered into the final data set used for analysis. This information was used primarily for demographic purposes, specifically for describing what types of crimes the juveniles had been detained for.

*Mental Health and Substance Abuse Screening Outcomes:* Because a primary purpose of this study was to understand what percentage of juveniles detained in Idaho appear to have mental health and/or substance abuse scores, it was important for the clinicians to provide information from a standardized screening instrument. As discussed in Brian Mecham's report on the 2006-2007 pilot project in the

Bonneville County JDC, when he first began working on the pilot project, Mr. Mecham evaluated three different instruments for screening mental health and substance abuse problems. One was the Massachusetts Youth Screening Inventory—Second Version, which is commonly abbreviated by clinical personnel as the MAYSI-II. The MAYSI-II is a computer-based, self-report inventory that is often used in juvenile detention facilities to help identify youth with mental health problems. The second was the CRAFFT, which is a brief assessment inventory used to identify youth who may have a substance abuse problem. The third was the Alaska Screening Tool (AST), which contains three subscales to measure mental health problems, substance abuse problems, and traumatic brain injury. Based on his work on the pilot study, Mr. Mecham determined that the MAYSI-II, although useful with some juveniles, was easily manipulated by others, yielding information with questionable validity; he determined the mental health subscale of the AST to be superior in identifying mental health problems. He also found the questions on the CRAFFT less useful in identifying substance abuse problems than the substance abuse subscale of the AST. Thus, for the purposes of the current study, only information from the AST mental health and substance abuse subscales was used for determining whether detained juveniles met the screening criteria for mental health and/or substance abuse problems. All AST screening information was entered into the clinician database as “True” or “False”. A designation of “True” meant that a juvenile met the criteria for the relevant problem (i.e., a mental health or substance abuse problem), whereas a designation of “False” meant that a juvenile did not meet the criteria for the problem. The traumatic brain injury subscale of the AST, although scored by clinicians, was not used as a variable in this evaluation.

*Previous Diagnoses:* During the clinical interview each detained juvenile had with the JDC clinician, each juvenile was asked whether he or she had ever been diagnosed with a mental health or substance abuse problem in the past. If the juvenile reported that he or she had been diagnosed in the past, he or she was asked how many diagnoses were given. The number of diagnoses was documented in the clinician database.

*Provisional Diagnoses:* A primary purpose of the entire clinical interview was to determine whether or not detained juveniles suffered from mental health and/or substance abuse problems. Clinicians made decisions about provisional diagnoses based on several pieces of information. Two such pieces of information were the AST mental health and substance abuse subscales; if juveniles met the diagnostic criteria for a mental health or substance abuse problem, it was highly likely that they would be provisionally diagnosed with the relevant problem. The other pieces of information were largely responses the juveniles made to questions posed by clinicians during the clinical interviews. A combination of all pieces of information was used by the clinicians to make their provisional diagnoses. The use of the word “provisional” is key in this context, as all clinicians, IDJC personnel, and BSU researchers involved in this project understood that a full clinical diagnosis takes more time to develop than the JDC clinicians had at their disposal during the intake interview.

In the clinician database, the clinicians first simply noted the number of provisional diagnoses made for each juvenile. Then, they entered information about what the diagnosis was (or diagnoses were, in the case of multiple diagnoses). A drop-down menu featured some generic options for clinicians to use if he or she chose (these generic options included “Mood Disorder”, “Substance Abuse Disorder”, and the like), however, the clinicians could also elect to type in their provisional diagnoses (and many chose to do so, particularly when they thought specificity was important). Prior to tabulating the numbers and percentages for each type of mental health or substance abuse problem, the researchers used a content analysis procedure to aggregate conceptually similar diagnoses (for example, combining

“depression”, “major depression”, and “bipolar disorder” into a larger category of “Mood Disorders”). Up to four provisional diagnoses were coded for each juvenile.

*Number of Recommended Services:* When juveniles were diagnosed with a mental health and/or substance abuse problem, the clinicians were to make recommendations for them to access community-based services upon their release (for example, if a juvenile was provisionally diagnosed as having depression, a clinician might recommend accessing counseling upon his or her release from the JDC). In the database, clinicians were asked to list the number of services that were recommended.

*Services Recommended:* All clinicians were asked to type in what type of service(s) they recommended for juveniles who had been given a provisional diagnosis. The researchers used a content analysis procedure to aggregate conceptually similar types of recommended services (for example, combining “complete clinical diagnosis”, “full mental evaluation”, and “psychiatric evaluation” into a larger category of “Psychological/Mental Evaluation”), and then tabulated the numbers and percentages for each type of recommended service. Up to four recommended services were coded for each juvenile.

*Recommended Services Accessed:* It was considered critical in this evaluation to gain some sense of how many recently released juveniles accessed at least some of the services that had been recommended for them by clinicians. To develop preliminary information on this, the clinicians asked the juveniles’ parents about whether they had accessed recommended services when they placed their follow-up calls to juveniles’ homes approximately 15 days after the juveniles were released from the JDC. When only one service had been recommended, the clinicians simply asked if that service had been accessed; when more than one service had been recommended, the clinicians asked how many of those services had been accessed. The number of services accessed was entered into the clinician database.

The first wave of data collection took place between January 1 and September 30, 2008. The first batch of data was submitted by clinicians from 10 of the 12 JDCs after June 30<sup>th</sup> (data were not submitted from the JDC in Canyon County, where a clinician had not been hired yet, and from the JDC in Lemhi County, which lost its data in a computer malfunction). The second batch of data was submitted by clinicians from 11 of the 12 JDCs after September 30<sup>th</sup> (data were again not provided from the JDC in Lemhi County, although this time computer malfunction was not to blame; complete information was only gathered on one juvenile, and there were concerns about violating confidentiality if data for only one juvenile were reported). Clinician data were sent directly to personnel at IDJC, who combined the data into a single Excel spreadsheet and ensured that all identifying information was removed before sending it to the BSU researchers for analysis. In total, data cases were provided for 2,060 juveniles.

### Wave Two: Parent Survey Data

The second wave of data collection involved the use of a survey of parents of juveniles who were recently released from a JDC. A parent survey had not been used as part of the evaluation of the pilot project in the JDC in Bonneville County, but it was considered to be desirable for several reasons. First, it was recognized that parents are important stakeholders in any project involving detained youth, and IDJC was very interested in their perceptions of it. Second, parents would be able to articulate better than clinicians whether their children received recommendations that were helpful to the family, and whether any barriers existed to accessing recommended services. Third, it was recognized that the

“number of services accessed”, which was captured to some extent in the clinician database, was probably a serious underestimate, because it only counted services that juveniles accessed between the date of release and the clinician follow-up calls placed approximately 15 days later. Because scheduling and attending an appointment for mental health or substance abuse services often takes time (many treatment providers, particularly in high-demand specialty areas such as psychiatry, are often booked up several months in advance), it was thought that many juveniles who would be accessing recommended treatment would not be accounted for by the number of services accessed question when it was asked by clinicians at 15 days post-release. Because the parent surveys were to be sent out no earlier than 45 days post-release, it was hoped that asking parents about whether their children had accessed recommended services would yield a more accurate count (as the juveniles should have had at least 30 more days to access recommended services).

The parent survey was developed jointly by the BSU researchers and IDJC personnel, and consisted of five items listed on a single page. These questions asked the parents: 1) whether they had been contacted by the JDC clinician and informed that their child had been identified as a person who might benefit from community-based mental health or substance abuse treatment; 2) whether the JDC clinician had given recommendations about what services their child should access in the community; 3) what services had been recommended for their child; 4) whether their child accessed at least one service recommended for him or her; and 5) why, if the child had not accessed the recommended service, he or she had not.

To ensure confidentiality and to avoid releasing the names or addresses of families who had a child recently detained in one of the JDCs, all mailing of surveys was handled directly by the clinicians or affiliated staff at the JDCs. The researchers at BSU prepared the survey packets, which included a mailing envelope, cover letter explaining the project as well as the voluntary and anonymous nature of participation, and a self-addressed postage-paid envelope for the parents to return the surveys directly to the researchers at BSU. After the survey packets were prepared, they were mailed directly from BSU to the JDCs. Personnel at IDJC had predetermined how many surveys to send to each JDC (which equaled approximately one-third of the juveniles detained at each JDC in the previous year). It was initially determined that 1,062 surveys would be mailed out. However, surveys were not sent to the JDC in Lemhi County, as first wave data had not been collected from that site, and also only 120 of the originally-estimated 270 surveys were sent to the JDC in Canyon County, as a clinician was hired late for that facility and it was surmised that a smaller-than-expected number of juveniles had been seen in that facility. Thus, only 888 surveys were sent to the JDCs for mailing to parents of recently released youth.

Only 48 completed surveys were returned by parents to the researchers at BSU, for a response rate of 5.4%. Although response rates are often relatively low to unsolicited surveys, this is a particularly low and disappointing rate of response that seriously calls into question the validity of the parent survey results.

### Wave Three: Judges/Juvenile Probation Officers Survey Data

The final wave of data collected for this project involved information gathered through a survey of judges and juvenile probation officers who worked with youth released from the county JDCs. A strategy of surveying judges/juvenile probation officers had been employed by Brian Mecham in his initial evaluation of the pilot study at the JDC in Bonneville County, and the results had been considered sufficiently valuable as to warrant a continuation of the survey effort in the expanded

evaluation described here. The original survey form drafted by Mr. Mecham was used again, with some minor modifications made by the BSU researchers to help capture a richer portrait of data (for example, the range of response options for reflecting satisfaction with clinician recommendations was expanded from a “Yes/No” format to a 1-5 rating scale). The modified survey instrument consisted of seven items (several of which had follow-up questions), asking the judges/juvenile probation officers: 1) if they were aware that the nearest JDC had a mental health clinician during the past year; 2) whether they had been contacted by the JDC clinician regarding one of their youth; 3) if they had been contacted, how satisfied they were with the contact (response options to this item ranged from “Very dissatisfied” to “Very satisfied”); 4) if they received recommendations on how to help youth with mental health issues; 5) if they had received recommendations, how satisfied they were with the recommendations (again, the response options ranged from “Very dissatisfied” to “Very satisfied”); 6) whether the recommendations they received affected any of the decisions or treatment they advised for youth; 7) how beneficial they thought it was to have a mental health clinician in the JDC (response options for this item ranged from “Not at all beneficial” to “Extremely beneficial”); and 8) whether they would like to see the clinical services program continue. They were also invited to share comments or recommendations related to the program.

Personnel at IDJC identified 113 judges/juvenile probation officers for the BSU researchers to send survey packets to, and they also provided the BSU researchers with the names and addresses for the clinicians (it was determined that because the names and addresses of the judges/juvenile probation officers were public record, there would be no confidentiality concerns incurred by the BSU researchers sending the surveys themselves). The researchers at BSU prepared the survey packets, which included a mailing envelope, cover letter explaining the project as well as the voluntary and anonymous nature of participation, and a self-addressed postage-paid envelope for the judges/juvenile probation officers to return the surveys directly to the researchers at BSU. A total of 50 completed surveys were returned by judges/juvenile probation officers prior the end of the data collection period, for a response rate of 44.3%. This response rate is very good for an unsolicited survey, and thus the results from the judges’/juvenile probation officers’ survey are considered to be high in representativeness or external validity.

Every aspect of this methodology, and the study in general, was reviewed and approved by BSU’s Institutional Review Board for the Protection of Human Subjects.

## Results and Analyses

### Analysis of JDC Data

#### Demographic Information

The data in this report are gleaned from the cases of 2,060 cases of juveniles detained at one of 11 JDCs throughout Idaho. Of these juveniles, 1,458 or 70.8% were boys and 602 or 29.2% were girls.

All cases submitted for analysis were coded to reflect the JDC in which each juvenile was booked. Eleven JDCs, each of which is listed below in Table 1, submitted cases during the study period. Ten of these submitted data during both the January 1 – June 30 initial data collection period and the July 1 – September 30 final data collection period. Data from the JDC in Canyon County were submitted only for the final data collection period. The 12<sup>th</sup> JDC that was originally intended to submit data for the study, which is in Lemhi County, did not submit data during either data collection period.

As seen below in Table 1, the largest percentage of cases submitted was from the JDC in Kootenai County (with over one-fourth of all cases), followed by the JDCs in Twin Falls County (nearly 16%), Bannock County (over 12%), Ada County (nearly 11%), and Nez Perce County (over 10%). On the other hand, the smallest percentages of cases were submitted from the JDCs in Valley County (less than 1%), Canyon County (1%), and Fremont County (less than 2%).

<b>Table 1: Number of Cases by Juvenile Detention Center (JDC) Location</b>		
<b>JDC Location</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
Ada County	225	10.9
Bannock County	249	12.1
Bonner County	118	5.7
Bonneville County (3B)	138	6.7
Canyon County	21	1.0
Fremont County (5C)	34	1.7
Kootenai County	552	26.8
Minidoka County	170	8.3
Nez Perce County	213	10.3
Twin Falls County (Snake River)	323	15.7
Valley County	17	.8

*Note.* Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Clinicians were asked to note the booking charge or charges for all juveniles whose information was entered into the database. At least one booking charge was noted for 1,997 of the juveniles, or 96.9% of all juveniles on whom data were collected, and two or more booking charges were noted for 457 (22.2%) juveniles. All booking charges were coded in accordance with the Uniform Crime Reporting (UCR) categories. As seen in Table 2, the most common class of booking charge was for “other” crimes that did not easily fit a UCR category (nearly 54% of the booking charges fit most appropriately in this “Other” category). Also as seen in Table 2, substantial numbers of juveniles were booked for drug crimes (nearly 23%), property crimes (22%), and crimes against persons (over 15%). Sex crimes were relatively uncommon among booking codes (accounting for less than 3% of all codes). The

researchers were unable to classify over 6% of the booking codes entered by clinicians, often because the booking codes were typed as abbreviations that the researchers were unable to decipher.

<b>Table 2: Most Common Booking Charges</b>		
<b>Booking Charge</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
“Other” crimes not easily fitting a category (e.g., joyriding, littering, sleeping in school)	1,077	53.9
Drug crimes	453	22.7
Property crimes	439	22.0
Crimes against persons	304	15.2
Unable to classify (e.g., discretionary days)	130	6.5
Sex crimes	51	2.6

*Note.* The percentages in this table are calculated out of the 1,997 juveniles who were assigned at least one booking charge in the IDJC database. Because up to four booking charges were coded for each individual, the total percentages in this table may exceed 100.

### AST Scores

As discussed earlier in this report, the Alaska Screening Tool (AST) was the primary instrument used for screening for mental health and substance abuse problems in the juveniles detained in the 11 JDCs. Also as discussed earlier, only data collected from the mental health and substance abuse subscales (not the traumatic brain injury subscale) were analyzed in this study and are reported upon in this report.

As seen below in Table 3, over two-thirds of the juveniles who were screened using the AST met the criteria for having a mental health problem. Also as seen in Table 3, over 54% of the juveniles screened with the AST met the criteria for having a substance abuse problem.

<b>Table 3: AST Indications of Mental Health and Substance Abuse Problems</b>		
<b>Condition</b>	<b>Number of Cases</b>	<b>Percentage of Total Screened Cases</b>
Mental health problem	1155	68.4
Substance abuse problem	920	54.5

*Note.* The percentages in this table are calculated out of the juveniles who were screened with the AST for the relevant condition.

To better understand whether boys and girls appeared to have mental health or substance abuse problems at a similar rate, we analyzed the distribution of diagnoses separately by juvenile gender. As seen below in Table 4, over 76% of the girls who were screened using the AST met the criteria for having a mental health problem, whereas slightly more than 65% of the boys appeared to have a mental health problem. A chi-square test revealed that the difference in mental health problems (at least as measured using the AST) was statistically significant,  $\chi^2$  (df = 1) 20.56,  $p < .001$ . Also as seen below in Table 4, boys and girls met the criteria for having a substance abuse problem at a similar rate, at 55% and slightly over 53%, respectively. This difference was not statistically significant.

**Table 4: AST Indications of Mental Health and Substance Abuse Problems, by Gender**

Condition	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Mental health problem	779	376	<i>65.1</i>	<i>76.4</i>
Substance abuse problem	658	262	55.0	53.3

*Note.* The percentages in this table are calculated out of the juveniles who were screened with the AST for the relevant condition. Contrasts in italics denote statistically significant differences.

Percentages of juveniles meeting the criteria for suffering from mental health and substance abuse disorders were also separated by JDC location, to determine whether the juveniles met the diagnostic criteria at similar rates across the 11 JDCs. As seen below in Table 5, there was a rather large spread of percentages for mental health problems as measured by the AST, ranging from slightly over half to all of the individuals in an individual JDC. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a mental health problem were Canyon County (where 100%, or all 21 screened juveniles met the criteria for a mental health problem), Bonner County (over 86%), and Fremont County (nearly 80%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were Valley County (nearly 53%), Bannock County (just over 53%), and Minidoka County (just over 62%). A chi-square test revealed that the differential rate of mental health problems as a function of JDC location was statistically significant,  $\chi^2$  (df = 10) 53.81,  $p < .001$ .

**Table 5: AST Indications of Mental Health Problems by JDC Location**

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	144	65.2
Bannock County	74	53.2
Bonner County	63	<b>86.3</b>
Bonneville County (3B)	90	65.7
Canyon County	21	<b>100.0</b>
Fremont County (5C)	27	<b>79.4</b>
Kootenai County	318	65.0
Minidoka County	28	62.2
Nez Perce County	159	77.2
Twin Falls County (Snake River)	222	72.5
Valley County	9	52.9

*Note.* The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for the relevant condition. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

An analysis for possible gender differences in the extent to which juveniles met the AST criteria for having a substance abuse disorder revealed that boys and girls met the criteria at similar levels. However, as seen below in Table 6, there were some noteworthy differences as a function of JDC location in the percentages of juveniles meeting the AST criteria for having a substance abuse problem. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Nez Perce County (where over 72% of the screened juveniles met the

criteria for a substance abuse problem), Bonner County (nearly 69%), and Canyon County (nearly 67%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Minidoka County (nearly just over 31%), Bonneville County (just over 42%), and Valley County (just over 47%). A chi-square test revealed that the differential rate of mental health problems as a function of JDC location was statistically significant,  $\chi^2$  (df = 10) 60.66,  $p < .001$ .

<b>Table 6: AST Indications of Substance Problems by JDC Location</b>		
<b>Condition</b>	<b>Number of Cases</b>	<b>Percentage of Total Screened Cases</b>
Ada County	118	53.4
Bannock County	74	53.2
Bonner County	50	<b>68.5</b>
Bonneville County (3B)	58	42.3
Canyon County	14	<b>66.7</b>
Fremont County (5C)	21	61.8
Kootnai County	238	48.7
Minidoka County	14	31.1
Nez Perce County	149	<b>72.3</b>
Twin Falls County (Snake River)	176	57.5
Valley County	8	47.1

*Note.* The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for the relevant condition. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

To gain a better understanding of the extent to which juveniles in detention in Idaho suffer from mental health problems and substance abuse problems separately and together (i.e., a dual diagnosis), we combined the information on mental health and substance abuse problems for each juvenile. In this way, juveniles were coded as having: 1) neither a mental health nor substance abuse problem (i.e., they met the AST criteria for neither condition); 2) a mental health problem only (i.e., they met the AST criteria for a mental health problem, but not a substance abuse problem); 3) a substance abuse problem (i.e., they met the AST criteria for a substance abuse problem, but not a mental health problem); and 4) both a mental health problem and a substance abuse problem (i.e., they met the AST criteria for both types of problems). As seen below in Table 7, a plurality of the juveniles (nearly 41%) who were screened with the AST met the diagnostic criteria for both a mental health and substance abuse disorder. The next largest group of juveniles (nearly 28%) met the AST criteria for a mental health problem only, followed by juveniles who met the criteria for neither type of problem (nearly 18%). The smallest group of juveniles (nearly 14%) met the criteria for a substance abuse problem only.

<b>Table 7: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both</b>		
<b>Condition</b>	<b>Number of Cases</b>	<b>Percentage of Total Screened Cases</b>
Neither mental health nor substance abuse problem	301	17.9
Mental health problem only	466	27.6

Substance abuse problem only	232	13.8
Both mental health and substance abuse problem	687	40.7

*Note.* The percentages in this table are calculated out of the juveniles who were screened with the AST for both conditions. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Again to determine whether boys and girls differentially met the diagnostic criteria for mental health and substance abuse problems (or neither or both), we analyzed how male and female juveniles were distributed across the four diagnostic categories (neither type of problem, a mental health problem only, a substance abuse problem only, and both types of problems). As seen below in Table 8, differences in the rates in which boys and girls fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant,  $\chi^2$  (df = 3) 22.77,  $p < .001$ . The largest difference found was in rates of meeting the diagnostic criteria for having substance abuse problem only; boys (at nearly 16%) were much more likely to fall into this diagnostic category than girls (at less than 9%). Boys (at nearly 19%) were also more likely than girls (at over 15%) to meet the diagnostic criteria for having neither a mental health nor a substance abuse problem. On the other hand, girls were more likely than boys (approximately 32% to 26%) to meet the diagnostic criteria for having a mental health problem only, and also to meet the diagnostic criteria for having both a mental health and a substance abuse problem (approximately 44% to 39%).

<b>Table 8: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both, by Gender</b>				
<b>Condition</b>	<b>Number of Cases</b>		<b>Percentage of Total Screened Cases</b>	
	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>
Neither mental health nor substance abuse problem	226	75	18.9	15.3
Mental health problem only	310	156	25.9	31.8
Substance abuse problem only	190	42	15.9	8.6
Both mental health and substance abuse problem	469	218	39.2	44.4

*Note.* The percentages in this table are calculated out of the juveniles who were screened with the AST for both conditions.

The pattern by which the juveniles met the respective criteria for the same four diagnostic categories was also examined as a function of JDC location. As seen below in Table 9, differences in the rates in which juveniles at the 11 JDCs fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant,  $\chi^2$  (df = 30) 124.13,  $p < .001$ . These differences may most easily be seen in visual analysis of the most and least common diagnostic categories that emerged for each JDC. As seen in Table 9, juveniles meeting the criteria for both a mental health and substance abuse problem were the largest single group in nine of the 11 JDCs, and juveniles meeting the criteria for a substance abuse problem only were the smallest single group in nine of the 11 JDCs. This was clearly the dominant pattern in the data as a whole. Marked deviations from this pattern were found for several of the JDCs. This is particularly true for the Minidoka County JDC, where the largest single group did not meet the diagnostic criteria for either a mental health or substance abuse problem. It is also true for the JDCs in Nez Perce and Twin Falls counties, where the least common single group did not meet the criteria for either a mental health or substance abuse problem. Other

interesting exceptions to the general pattern were in the Bonneville County JDC, where the largest single group met the criteria for a mental health problem only, and in the Valley County JDC, where the largest groups fell jointly into the “neither” and “both” problem categories.

<b>Table 9: AST Indications of Mental Health Problems, Substance Abuse Problems, and Comorbid Existence of Both, by JDC Location</b>				
<b>Condition</b>	<b>Neither MH nor SA</b>	<b>MH only</b>	<b>SA only</b>	<b>Both MH and SA</b>
Ada County	18.6 (N = 41)	27.7 (N = 61)	16.8 (N = 37)	<b>36.8</b> (N = 81)
Bannock County	26.6 (N = 37)	20.1 (N = 28)	20.1 (N = 28)	<b>33.1</b> (N = 46)
Bonner County	11.0 (N = 8)	20.5 (N = 15)	2.7 (N = 2)	<b>65.8</b> (N = 48)
Bonneville County (3B)	24.1 (N = 33)	<b>35.0</b> (N = 48)	10.2 (N = 14)	30.7 (N = 42)
Canyon County	0.0 (N = 0)	33.3 (N = 7)	0.0 (N = 0)	<b>66.7</b> (N = 14)
Fremont County (5C)	11.8 (N = 4)	26.5 (N = 9)	8.8 (N = 3)	<b>52.9</b> (N = 18)
Kootnai County	21.1 (N = 103)	30.5 (N = 149)	13.5 (N = 66)	<b>34.8</b> (N = 170)
Minidoka County	<b>35.6</b> (N = 16)	33.3 (N = 15)	2.2 (N = 1)	28.9 (N = 13)
Nez Perce County	8.3 (N = 17)	19.4 (N = 40)	27.6 (N = 40)	<b>57.8</b> (N = 119)
Twin Falls County (Snake River)	12.1 (N = 37)	29.4 (N = 90)	15.7 (N = 48)	<b>42.8</b> (N = 131)
Valley County	<b>29.4</b> (N = 5)	23.5 (N = 4)	17.6 (N = 3)	<b>29.4</b> (N = 5)

*Note.* The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for both conditions. N denotes the number of cases in each table cell. Percentages are rounded to the first decimal place, so the total percentage across rows may not equal 100. The highest row percentages are presented in bold, and the lowest row percentages are presented in italics.

#### Previous and Provisional Diagnoses

During the clinical interview for each juvenile, the clinicians at each JDC asked whether the juvenile had ever been diagnosed with a mental health or substance abuse problem in the past. If the juveniles reported that they had been diagnosed with such a problem in the past, the clinicians asked them how many separate diagnoses they had been given. This information was used to create a number of “previous diagnoses” for each juvenile.

At least one previous diagnosis of a mental health or substance abuse disorder was recorded for 1,218 juveniles (or 59.1% of all juveniles on whom data was collected). The mean number of previous diagnoses for juveniles (of both genders and across the 11 JDCs) with at least one previous diagnosis was 1.26 (standard deviation = .55). The range of previous diagnoses spanned from none to five. The

mean numbers of previous diagnoses were found to be similar for boys (1.26) and girls (1.24), and no significant difference was found between them. The mean number of previous diagnoses did differ significantly, however, as a function of JDC location,  $F(10, 1207) = 13.66, p < .001$ . As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Ada, Nez Perce, and Fremont counties. The JDCs with the lowest number of mean previous diagnoses were in Bonneville, Valley, and Kootenai counties.

<b>Table 10: Number of Previous Diagnoses by JDC Location</b>			
<b>JDC Location</b>	<b>Number of Cases</b>	<b>Mean</b>	<b>Standard Deviation</b>
Ada County	100	<b>1.55</b>	.78
Bannock County	167	1.22	.50
Bonner County	20	1.40	.60
Bonneville County (3B)	137	<i>1.08</i>	.27
Canyon County	21	1.14	.48
Fremont County (5C)	4	<b>1.50</b>	.58
Kootenai County	387	<i>1.10</i>	.32
Minidoka County	13	1.15	.38
Nez Perce County	201	<b>1.51</b>	.75
Twin Falls County (Snake River)	157	1.33	.59
Valley County	11	<i>1.09</i>	.30

*Note.* Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

Clinicians at all JDCs used the diagnostic information from each juvenile's AST scores and information from a brief clinical interview to determine whether to make a "provisional diagnosis" of a mental health or substance abuse problem for that juvenile (the term "provisional diagnosis" was used rather than simply "diagnosis" in recognition that a full clinical diagnosis could not reasonably be made in such a short interview). In cases in which clinicians felt that more than one provisional diagnosis was warranted (for example, if a clinician believed a juvenile had depression and a substance abuse problem), they could give multiple provisional diagnoses.

At least one provisional diagnosis of a mental health or substance abuse disorder was recorded for 1,719 juveniles (or 83.5% of all juveniles on whom data was collected). The mean number of provisional diagnoses for juveniles (of both genders and across the 11 JDCs) with at least one provisional diagnosis was 1.56 (standard deviation = .76). The range of provisional diagnoses spanned from none to six. A statistically significant difference in mean number of provisional diagnoses was found to exist between boys (1.53) and girls (1.62), with girls receiving significantly more provisional diagnoses than boys,  $t(1717) = -2.16, p < .05$ . The mean number of provisional diagnoses also significantly differed as a function of JDC location,  $F(10, 1708) = 80.77, p < .001$ . As seen below in Table 11, the JDC with the highest number of mean provisional diagnoses was in Nez Perce County, followed by the JDCs in Bonner and Ada counties. The JDC with the lowest number of mean provisional diagnoses was in Kootenai County, followed by the JDCs in Bannock and Minidoka counties.

**Table 11: Number of Provisional Diagnoses by JDC Location**

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	168	<b>1.97</b>	.90
Bannock County	149	<i>1.20</i>	.43
Bonner County	82	<b>2.02</b>	.74
Bonneville County (3B)	135	1.36	.53
Canyon County	21	1.62	.50
Fremont County (5C)	32	1.94	.62
Kootnai County	473	<i>1.10</i>	.31
Minidoka County	149	<i>1.28</i>	.53
Nez Perce County	208	<b>2.30</b>	.84
Twin Falls County (Snake River)	285	1.79	.76
Valley County	17	1.59	.80

*Note.* Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

All clinicians who made provisional diagnoses were asked to indicate what the diagnoses were for each individual. This was not accomplished in all cases; although, as noted above, 1,719 juveniles were reportedly given at least one provisional diagnosis, in only 1,316 of these cases did clinicians indicate what the diagnosis was (or diagnoses were, if multiple diagnoses were made). Although some basic categories were provided in drop-down menus in the clinicians' Access databases, they were allowed to type in the provisional diagnoses given, and often chose to do so. A content analysis procedure was used to classify all typed answers into conceptually consistent themes. As seen below in Table 12, by far the most common diagnosis given was for a mood disorder; over half of the juveniles for whom a provisional diagnosis was listed were diagnosed with a mood disorder. Two other diagnoses that were given with some frequency were substance abuse disorders and disruptive behavior disorders. The former was given to over 40% of juveniles for whom a provisional diagnosis was listed. The latter (which was a broad category encompassing several more specific disorders, the most common of which were oppositional defiant disorder and disruptive disorder) was given to nearly one-third of the juveniles for whom a provisional diagnosis was listed. Two other classes of disorders that were listed with some frequency were anxiety disorders (the most common single anxiety disorder listed was post-traumatic stress disorder, or PTSD) and attention deficit disorders (most commonly attention deficit hyperactivity disorder, or ADHD).

**Table 12: Most Common Provisional Diagnoses**

Provisional Diagnosis	Number of Cases	Percentage of Total Cases
Mood disorders (e.g., depression, bipolar disorder)	666	50.6%
Substance abuse disorders (e.g., marijuana or alcohol abuse)	530	40.3%
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	425	32.3%
Anxiety disorders (e.g., post-traumatic stress disorder)	205	15.6%
Attention deficit disorders (e.g., ADHD/ADD)	134	10.2%

*Note.* The percentages in this table are calculated out of 1,316 juveniles for whom at least one provisional diagnosis was noted in the IDJC database. Because up to three provisional diagnoses were coded for each individual, the total percentages in this table may exceed 100.

### Recommendations for Services

At least one recommendation for services was recorded for 1,523 juveniles (or 88.6% of the 1,719 for whom at least one provisional diagnosis was given). The mean number of recommended services for those juveniles (of both genders and across the 11 JDCs) who were given at least one service recommendation was 1.77 (standard deviation = .93). The range of recommended services spanned from none to six. A statistically significant difference in mean number of recommended services was found to exist between boys (1.68) and girls (1.95), with girls receiving significantly more service recommendations than boys,  $t(1521) = -5.15, p < .001$ . The mean number of recommended services also differed significantly as a function of JDC location,  $F(10, 1512) = 20.41, p < .001$ . As seen below in Table 13, the JDCs with the highest number of mean recommended services were in Bonner and Twin Falls counties, followed by the JDC in Canyon County. The JDCs with the lowest number of mean recommended services were in Ada and Bonneville counties, followed by the JDC in Nez Perce County.

**Table 13: Number of Recommended Services by JDC Location**

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	122	<i>1.30</i>	<i>.67</i>
Bannock County	181	1.71	.95
Bonner County	90	<b>2.26</b>	.91
Bonneville County (3B)	135	<i>1.33</i>	<i>.55</i>
Canyon County	20	<b>2.10</b>	<i>.72</i>
Fremont County (5C)	30	2.07	.91
Kootnai County	480	1.62	.82
Minidoka County	74	1.82	.93
Nez Perce County	64	<i>1.58</i>	<i>.87</i>
Twin Falls County (Snake River)	311	<b>2.23</b>	1.08
Valley County	16	1.81	<i>.75</i>

*Note.* Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

All clinicians who indicated that they had recommended at least one service for a juvenile were asked to indicate what the recommended service(s) was. This was not accomplished in all cases; although, as noted above, 1,513 juveniles were reportedly given at least one recommendation for a service, in only 1,145 of these cases did clinicians indicate what the recommended service was (or recommended services were, if multiple recommendations were given). Although some basic categories were provided in drop-down menus in the clinicians' Access databases, they were allowed to type in the service recommendation(s) given, and often chose to do so. A content analysis procedure was used to classify all typed answers into conceptually consistent themes. As seen below in Table 14, by far the most common recommendation given was for individual counseling; nearly 70% of the juveniles for whom a recommended service was listed were recommended to access individual counseling. The

second-most common recommendation, made for over one-third of the juveniles for whom a recommendation was made, was for a psychological or mental evaluation (this recommendation seems particularly prudent given that the clinicians knew they could only make quick assessments based on brief encounters and limited information). The third-most common recommendation was for substance abuse counseling or treatment, which was made for slightly under one-third of the juveniles who received at least one recommendation. Other recommendations that were made with some frequency included substance abuse assessment, family counseling, psychosocial rehabilitation, and an evaluation of medications taken.

<b>Table 14: Most Common Service Recommendations</b>		
<b>Service Recommendation</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
Individual counseling (e.g., Cognitive Behavioral Therapy)	797	69.6%
Psychological/mental evaluation	415	36.3%
Substance abuse counseling/treatment	368	32.1%
Substance abuse assessment	113	9.9%
Family counseling	108	9.4%
Psychosocial rehabilitation	90	7.9%
Medication evaluation	84	7.3%

*Note.* The percentages in this table are calculated out of the juveniles who were assigned at least one service recommendation in the IDJC database. Because up to three service recommendations were coded for each individual, the total percentages in this table may exceed 100.

#### Recommended Services Accessed

All clinicians who made at least one recommendation for services were asked, when they completed follow-up calls to a parent/guardian of each juvenile 15 days after release, whether or not the recommended service(s) had been accessed. The mean number of recommended services accessed, for those juveniles (of both genders and across the 11 JDCs) who were given at least one service recommendation, was .86 (standard deviation = .96). The range of recommended services accessed spanned from none to five. No statistically significant difference in mean number of recommended services accessed was found between boys (.84) and girls (.88), suggesting that juveniles accessed services similarly regardless of their gender. The mean number of recommended services did differ significantly, however, as a function of JDC location,  $F(10, 1513) = 24.18, p < .001$ . As seen below in Table 15, the JDC with the highest number of mean recommended services accessed was in Twin Falls County, followed by the JDCs in Bannock and Kootenai counties. The JDC with the lowest number of mean recommended services accessed was in Minidoka County, followed by the JDCs in Canyon and Ada Counties.

<b>Table 15: Number of Recommended Services Accessed by JDC Location</b>			
<b>JDC Location</b>	<b>Number of Cases</b>	<b>Mean</b>	<b>Standard Deviation</b>
Ada County	122	.31	.48
Bannock County	181	<b>1.11</b>	.86
Bonner County	90	.36	.75
Bonneville County (3B)	135	.82	.75

Canyon County	20	<i>.15</i>	<i>.67</i>
Fremont County (5C)	30	<i>.53</i>	1.04
Kootenai County	480	<b>1.05</b>	<i>.97</i>
Minidoka County	74	<i>.01</i>	<i>.17</i>
Nez Perce County	64	<i>.50</i>	<i>.69</i>
Twin Falls County (Snake River)	311	<b>1.16</b>	1.10
Valley County	17	<i>.47</i>	<i>.80</i>

*Note.* Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

### Parent Survey

As discussed earlier in this report, the second phase of data collection involved conducting a survey of parents of recently released juveniles who had been given at least one provisional diagnosis of a mental health or substance abuse problem to determine whether or not they had been contacted by JDC clinicians and provided with recommendations for services for their children. Part of the protocol used by JDC clinicians was to provide each provisionally diagnosed juvenile who was being released with at least one recommendation for services, and then to follow up with each juvenile's parent by telephone 15 days after release. During this follow-up contact, the JDC clinicians were to ask each parent if he or she was aware of any recommendation that had been made, and if he or she was, to inquire whether the juvenile had accessed the recommended service. A principal part of the rationale for the parent survey was to determine if the parents of recently received juveniles had been contacted by the appropriate JDC clinician and whether or not the juveniles had accessed the recommended services. Because it was recognized by the research team that not many of the juveniles would have had time to access recommended services by the time the 15-day follow-up call had been placed (largely due the time required to schedule an appointment), it was believed that the parent survey would provide a much more accurate portrait of the number of juveniles who accessed the recommended service.

As noted earlier in this report, only a very small percentage (less than 6%) of the parents who were mailed a survey returned one. The response rate was so low that it would be unwise to attempt to generalize the responses of those parents who did complete the survey to all potential parent respondents. Still, it is believed that the data from the parents who did respond have some value, and this data is presented below, sequentially for the five items on the survey.

### JDC Clinician Calls

The first question on the parent survey simply asked the respondents whether the JDC clinician had made them aware that their child had been identified as someone who could benefit from community-based mental health or substance abuse treatment. All 47 parents who returned a survey answered this question. Of these parents, 21 (44.7%) responded "Yes" that they had been made aware of this, and 26 (55.3%) responded "No" that they had not been made aware. A statement on the survey informed those who responded "No" to this first question that they were not required to complete the remaining items, and to simply return the survey as it was. Parents who responded "Yes" were asked to complete the next item.

The second question on the survey asked the respondents whether the JDC clinician made recommendations for what services their child should access in the community. Of the 20 parents who completed this item, 19 (or 95.0%) reported that they had received recommendations for services. A statement on the survey informed those who responded “No” to this second question that they were not required to complete the remaining items, and to simply return the survey as it was. Parents who responded “Yes” were asked to complete the remaining items.

### Recommended Services

The third question asked the respondents what recommendations for services they received from the JDC clinicians, and had several blanks for the parents to write information. All written answers were analyzed with a content analysis procedure, and when possible were clustered into conceptually similar themes. A total of 17 parents wrote in at least one recommended service, and eight wrote in two. As seen below in Table 16, the most commonly reported service recommendation was for mental health evaluation/treatment, which was reported by over 40% of the parents who reported receiving at least one service recommendation. Two other service recommendations that were reportedly received fairly often were for substance abuse treatment or support groups (such as Alcoholics Anonymous) and family service programs or organizations (e.g., “Family Recovery Center”, “parent-teen program”).

<b>Table 16: Most Commonly Received Service Recommendations</b>		
<b>Service Recommendation</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
Mental health evaluation/treatment	7	41.2
Substance abuse treatment/support groups	5	29.4
Family services programs/organizations	4	23.5

*Note.* The percentages in this table are calculated out of the 17 parents who reported that their child received at least one service recommendation.

The fourth question asked parents whether or not their children had accessed the service(s) that had been recommended to them. Of the 14 parents who completed this item, 13 (or 92.3%) reported that their children had accessed at least one recommended service.

### Barriers to Access

The final question on the survey asked the parents to report any barriers to accessing services, if their child had not accessed at least one recommended service. Only three parents wrote a response to this item. Two of the three reported that their children refused to access the service, and the third reported not being able to afford whatever service had been recommended to him or her.

### Judges and Probation Officers Survey

As discussed earlier in this report, the third phase of data collection involved a survey of judges and juvenile probation officers who worked with youth detained in one of the JDCs. Because one of the goals of the clinical services program is to provide helpful information to law enforcement personnel who work with detained youth, the perceptions of these judges and juvenile probation officers were considered very important. The judges’/juvenile probation officers’ survey consisted of seven questions asking about contact with the JDC clinicians, the value of information received from JDC

clinicians, and the overall value of the program. The responses to these items are discussed below. Because, as noted earlier in this report, the response rate from judges'/juvenile probation officers' surveys was high (over 44%), the validity of and ability to generalize these results are considered much better than those of the parents' survey results.

### Program Awareness

The first item on the survey simply asked the judges/juvenile probation officers whether or not they were aware that the closest JDC had a mental health clinician in the past year. Of the 50 judges/juvenile probation officers who completed this item, 33 (or 66.0%) reported that they were aware that the closest JDC had a clinician in it. A statement on the survey informed those who responded "No" to this first question that they were not required to complete the remaining items, and to simply return the survey as it was. Judges/juvenile probation officers who responded "Yes" were asked to complete the next item.

### Satisfaction With Contact

The second item on the survey asked the judges/juvenile probation officers whether they had been contacted by the JDC clinician regarding one of the juveniles they worked with. Of the 34 judges/juvenile probation officers who completed this item, 27 (or 79.4%) reported that they had been contacted by the JDC clinician about at least one of their juveniles. A statement on the survey informed those who responded "No" to this second question that they were not required to complete the remaining items, and to simply return the survey as it was. Judges/juvenile probation officers who responded "Yes" were asked to complete the remaining items.

Those judges/juvenile probation officers who reported having been contacted by the JDC clinician about at least one of their youth were asked to indicate how satisfied they were with this contact. They were allowed to indicate their satisfaction on a five-point Likert-type scale with values ranging from 1 = Very Dissatisfied to 5 = Very Satisfied. As seen below in Table 17, nearly 90% of those judges/juvenile probation officers who completed this item reported being very satisfied (fully 50%) or satisfied (nearly 39%) with the contact with the JDC clinician. Two judges/juvenile probation officers (or nearly 8% of all who completed this item) reported being very dissatisfied with contact with JDC clinicians, and one (representing nearly 4% of the total) reported not being satisfied or dissatisfied.

**Table 17: Satisfaction with Contact with JDC Clinicians**

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the contact you had with the mental health clinician?	7.7% (N = 2)	0.0% (N = 0)	3.8% (N = 1)	38.5% (N = 10)	50.0% (N = 13)

*Note.* The percentages in this table are calculated out of the 26 judges/juvenile probation officers who reported a level of satisfaction with contact with a JDC clinician. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

The third item asked the judges/juvenile probation officers whether they received recommendations from the JDC clinicians to help youth with mental health issues. Of the 27 judges/juvenile probation officers who completed this item, 25 (or 92.6%) reported that they had received such

recommendations. All judges/juvenile probation officers who reported having received recommendations were asked to indicate on a five-point Likert-type scale how satisfied they were with the recommendations made. As seen below in Table 18, nearly 80% of the judges/juvenile probation officers who completed this item reported being either satisfied (nearly 46%) or very satisfied (over 33%). Only two judges/juvenile probation officers, representing less than 9% of the total who responded to this question, reported being dissatisfied (4.2%) or very dissatisfied (4.2%) with clinicians' recommendations. Three judges/juvenile probation officers, or less than 13% of those who responded, reported not being satisfied or dissatisfied with the recommendations.

<b>Table 18: Satisfaction with Recommendations from JDC Clinicians</b>					
<b>Item</b>	<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Not Satisfied or Dissatisfied</b>	<b>Satisfied</b>	<b>Very Satisfied</b>
How satisfied were you with the recommendations made by the mental health clinician?	4.2% (N = 1)	4.2% (N = 1)	12.5% (N = 3)	45.8% (N = 11)	33.3% (N = 8)

*Note.* The percentages in this table are calculated out of the 24 judges/juvenile probation officers who reported a level of satisfaction with recommendations from JDC clinicians. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

The fourth item asked the judges/juvenile probation officers who reported receiving recommendations from JDC clinicians whether these recommendations had affected any of the decisions or treatment they advised for their youth. Of the 27 judges/juvenile probation officers who completed this item, 20 (or 74.1%) reported that the recommendations they received had affected a decision or treatment advised for the youth. Those respondents who answered "No" to this item were asked to write (in a blank provided on the survey) why the recommendations did not affect their decisions or advised treatment. Seven judges/juvenile probation officers wrote at least one comment in response to this item. Five of these written comments suggested that the respondents did not feel the clinicians' recommendations added any value to what they already thought or knew (e.g., "The recommendation did not tell us anything I did not already know", "As a probation officer, I was already aware of the juvenile's needs and referrals to programs had already been made", "the recommendations coincided with what we intended"), and two of the written comments critical and negative ("clinician had no knowledge whatsoever of previous treatment the youth had received, so his recommendations were irrelevant and misleading. More harm than good", "We receive the info too late. I have not received an assessment in over two months... There is no communication with her and the probation office").

The fifth item on the survey asked the judges/juvenile probation officers how beneficial they thought it was to have a clinician in the nearest JDC. The judges/juvenile probation officers were allowed to indicate how beneficial they thought it was to have clinicians in the JDCs on a five-point Likert-type scale with values ranging from 1 = Not at all beneficial to 5 = Extremely beneficial. As seen below in Table 19, nearly 60% of the judges/juvenile probation officers who completed this item reported thinking it was very beneficial to have a clinician in the nearest JDC, and another nearly 19% reported it to be beneficial. Slightly over 11% reported being neutral with respect to an answer, and an identical percentage reported thinking it was not at all beneficial (7.4%) or not very beneficial (3.7%) to have a clinician in the JDC.

<b>Table 19: How Beneficial It Is to Have a Clinician in the JDCs</b>					
<b>Item</b>	<b>Not at all Beneficial</b>	<b>Not Very Beneficial</b>	<b>Neutral</b>	<b>Rather Beneficial</b>	<b>Extremely Beneficial</b>

How beneficial do you think it is to have a mental health clinician in the detention center?	7.4% (N = 2)	3.7% (N = 1)	11.1% (N = 3)	18.5% (N = 5)	59.3% (N = 16)
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*Note.* The percentages in this table are calculated out of the 27 judges/juvenile probation officers who reported on how beneficial it is to have a clinician in the JDCs. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

The final item on the survey asked the judges/juvenile probation officers whether they would like to see the program housing clinicians in the JDCs continue. Of the 25 judges/juvenile probation officers who completed this item, 23 (or 92.0%) reported that they would like to see the clinical services program continue. All judges/juvenile probation officers were then asked to explain why they would or would not like to see the program continue, and 12 chose to do so. Eleven written responses commented on positive perceived elements of the program as evidence for why it should continue (e.g., “It enables us to get a more accurate assessment of youth because the clinician is on site”, “the screening recommendations have been extremely beneficial when making recommendations to the courts...they have also been beneficial to our probation officers in developing case plans”, “it is helpful, especially to parents who don’t know where to turn), and one of the comments was neutral in tone (“I am indifferent...We have had the clinician for about four months and I have not seen a significant impact on my work load or decisions I make”).

## **Summary and Conclusions**

The material in this report describes the results of the multimodal evaluation of the IDJC's clinical services program. In this report, the evaluation methodology and results generated through three waves of collection are presented. To this point, the results have been discussed with a focus on individual findings, without much attempt to understand them as a more coherent whole. In the final section of this report, a more comprehensive overview of the results and their implications will be presented, with special emphasis on several themes, including the methodology, mental health and substance abuse issues, service recommendations and service access, and stakeholder perceptions.

### Methodology

To a large extent, the methodology employed in this study seemed sound and yielded quality data. This is particularly true of the third wave of data collection, in which the BSU researchers received accurate, up-to-date addresses for judges and juvenile probation officers, were able to send surveys to all law enforcement personnel identified by IDJC, and found a high response rate in terms of returned surveys; the third wave data were of high quality and validity. The first wave data collection process also generally worked well, although the lack of any data from the JDC in Lemhi County was unfortunate, and may limit the ability to generalize the results to juveniles in that facility. The BSU researchers generally found that, although data from some JDCs were typically submitted late (thus delaying analyses), these data were mostly error-free and required relatively little correction or clarification.

The surprisingly low response rate to the parent survey seriously calls into question the validity of the results gleaned from these surveys, and the value of the second wave of data collection in general. Clearly, the parents who received these surveys were unwilling or unable to answer the survey items, or at the very least they did not perceive the survey effort to be sufficiently valuable to contribute their perceptions. Without further exploration into why a greater percentage of surveys were not returned, or without modification to the data collection process, the benefits of a parent survey do not seem worth the cost incurred by IDJC or the effort expended by the researchers. If future evaluations of the clinical services program are conducted, and feedback from parents is desired, it seems that efforts to improve the survey process are warranted. Several strategies to improve this process appear to exist. For example, convening a focus group of representative parents of recently released youth would help researchers word the cover letter and survey items in such a way that might encourage higher rates of responding. Members of this focus group would bring a unique perspective to help researchers understand how to communicate to parents that their responses are truly important and may help to shape the future of a successful program for juveniles and families like their own. It would also enable the researchers to ensure that the parents understand the questions being asked, and feel able to meaningfully respond to the questions as well. Another strategy might be to inform parents when their children are being released that a survey will be mailed to them in the near future. A "heads-up" message of this type might increase the likelihood that parents do not simply discard without understanding what it is, as well as communicate to parents that the JDC clinicians and related personnel continue to care about their children even after they have been released from detention.

### Mental Health and Substance Abuse Issues

As discussed earlier in this report, a major purpose behind the clinical services program was to gain an understanding of what percentage of detained juveniles have mental health and/or substance abuse problems. Several pieces of information gathered in this evaluation suggest that the number of juveniles with these problems is very high. As noted earlier in this report, nearly 60% of the juveniles on whom data were collected revealed that they had been diagnosed with a mental health or substance abuse problem *before* being detained in a JDC (i.e., they had at least one “previous diagnosis”). After being detained and completing a clinical interview, at least one provisional diagnosis was made for nearly 84% of the juveniles. Of those who were provisionally diagnosed, a dual diagnosis of a mental health and a substance abuse problem was the most common result. These figures together reveal several important findings, including: 1) numerous parents and community treatment professionals knew most of these juveniles were dealing with some serious problems even before they were detained; 2) many previously undiagnosed cases of mental health or substance abuse problems were identified through the clinical services program; and 3) many of the juveniles detained have complex, interrelated problems that likely require complex, interrelated treatment strategies.

Each of these three points is important in itself, and seems to deserve further discussion. The first, that many juveniles who are eventually detained in a JDC were previously known to have a mental health and/or substance abuse problem, strongly suggests that more effective community-based screening and intervention efforts are needed. Although the purpose of this evaluation is to comment on the value of the clinical services program in the JDCs, it cannot be ignored that community-level efforts to identify and treat mental health and substance abuse problems in at-risk juveniles would be beneficial, so that many of these juveniles would never be detained in the JDCs. It is possible that the JDC clinicians, or personnel affiliated with IDJC or IDHW, could work with school district staff (e.g., counselors, nurses, teachers) to encourage them to identify juveniles who may have mental health or substance abuse problems, and refer them to appropriate community-based services, in the hopes that these juveniles can be helped before they become enmeshed in the juvenile justice system.

The second point, that many previously undiagnosed mental health or substance abuse problems were identified through the clinical services program, is also important. Before reflecting on it, however, let us return to the numbers revealed earlier in this report. Clinicians noted in their databases that 1,218 juveniles reported that they had previously been diagnosed with a mental health or substance abuse problem, and that they assigned provisional diagnoses to 1,719 juveniles. The difference in these two figures—501—reflects the number of juveniles who likely had a mental health or substance abuse problem that would not have been diagnosed had clinicians not been working in the JDCs. These 501 juveniles represent 24.3% of the total number of cases in this study. That the clinical services program helped identify likely problems in such a large percentage of detained juveniles seems to provide tremendous support for its value as a program. Furthermore, the finding that 84% of detained youth appear to have a mental health and/or substance abuse problem—whether diagnosed previously or in the JDCs—also provides evidence for the need for clinicians in the JDCs.

The third point is focused primarily on the complex nature of the problems provisionally diagnosed in many of the juveniles in this evaluation study. As noted earlier, AST screening scores showed that nearly 41% of the juveniles met the criteria for both a mental health problem and a substance abuse problem; this percentage is much greater than that for juveniles meeting only the criteria for a mental health problem (28%), only a substance abuse problem (14%), or not meeting the criteria for either type of problem (18%). There is an expansive literature spanning multiple disciplines (including criminal justice, counseling, psychology, and social work, to name a few) on the unique challenges faced by people with a dual diagnosis of a mental health and substance abuse disorder, and on the

special needs they have in treatment and aftercare. Many mental health and addiction researchers have commented on the difficulty people with dual diagnoses have in accessing treatment and aftercare that comprehensively address both mental health and substance abuse problems, and this difficulty has special implications for the clinical services program. Quite simply, it may not be easy for clinicians, when making recommendations for post-release services, to identify comprehensive service providers for dually diagnosed juveniles (especially in rural and remote parts of Idaho where services of all types may be limited). Encouraging the development or maintenance of networks of mental health and substance abuse service providers may be necessary, and this may be a goal more easily achieved by policymakers than by state agency or JDC staff.

### Service Recommendations and Access

Although understanding the prevalence of mental health and substance abuse problems among detained juveniles was an important purpose of the clinical services program, it certainly was not the only one. Perhaps a more fundamental purpose of the program was to help link screened juveniles with mental health and substance abuse treatment services, both in the JDCs and outside of them. In this evaluation, the linkage to services outside of the JDCs (i.e., in the community) was the primary focus. In short, when clinicians made a provisional diagnosis of detained juveniles, the clinicians were to develop one or more recommendations for community-based services to provide to juveniles (and their parents) when they were released. They were also charged with doing whatever they could to ensure juveniles accessed those services upon release. Their success in these efforts may be measured several ways. One measure of success is the percentage of individuals who were given at least one provisional diagnosis and who also received at least one recommendation for a community-based service. Another is the percentage of juveniles who received at least one service recommendation and who also accessed at least one service.

As was discussed earlier in this report, a total of 1,719 juveniles were given at least one provisional diagnosis of a mental health or substance abuse disorder. Also as discussed earlier, 1,513 juveniles received at least one recommendation for a community-based service. Thus it can be concluded that 88% of provisionally diagnosed individuals received at least one service recommendation. Although determining what percentage constitutes “success” in recommending services is inherently subjective, recommending services for nearly 90% of provisionally diagnosed juveniles is certainly quite good. Furthermore, it seems noteworthy and a positive commentary on the clinicians that one of the most commonly reported recommendations they gave was for a full evaluation—either by mental health or substance abuse professional. Clearly, the clinicians recognized their own limitations in only being able to use a general screening inventory (the AST) and brief clinical interview, and sought a more detailed, comprehensive evaluation for the juveniles they saw. Very likely, the more comprehensive evaluations received by the juveniles, if they followed the clinicians’ recommendations for accessing these evaluations from community-based service providers, could link them with the types of treatment and support that would maximize their chances for addressing their mental health or substance abuse problems.

Unfortunately, it is difficult to measure the extent to which the clinicians were successful in facilitating access to services for the juveniles. The only concrete measure of value for services access are clinicians’ own reports of whether juveniles had accessed recommended services, and these reports were made from answers to questions the clinicians asked during their follow-up telephone calls made approximately 15 days post-release. As discussed earlier in this report, because 15 days is a short period of time for anyone to access many specialized mental health and substance abuse services, the

percentage of juveniles who accessed services by the time of the 15-day follow-up calls is almost certainly an underestimate of the percentage of juveniles who eventually would access recommended services. We know from the clinicians' data that 810 of the 1,523 juveniles who received at least one service recommendation accessed at least one service, and at 53%, this is certainly not a small percentage. If we assume that at least half of those who had not accessed a recommended service by the 15-day follow-up call accessed a recommended service after this call, we could estimate that three-fourths of the juveniles who received at least one service recommendation accessed at least one recommended service. Of course, this requires some conjecture, and conjecture—especially in evaluation—is hardly desirable. Had the surveys to parents, which were generally sent more than 30 days after the follow-up calls, led to a better rate and more valid results, we would certainly have a much clearer picture of what percentage of juveniles eventually accessed a recommended service.

### Stakeholder Perceptions

The IDJC personnel who commissioned and funded this evaluation were very interested in stakeholder perceptions of the clinical services program, in recognition that if key stakeholders are not satisfied with a program, that program is not likely to be effective. The two key stakeholder groups in this evaluation were parents and law enforcement personnel—the latter category being a combination of judges who adjudicate cases involving detained juveniles and the juvenile probation officers that monitor those juveniles after their release from the JDCs. As discussed earlier, the low response rate to the parent survey makes it impossible to generalize the responses to that survey to the entire population of parents. Therefore, we must conclude that we still know next to nothing about how parents perceive the clinical services program. We know more, however, about how the judges/juvenile probation officers perceive the program, as the response rate to their survey was much higher than what is typically reported in social science research. In short, clear majorities of the judges/juvenile probation officers who were aware of the program and who had contact with a clinician were satisfied with the contact and were satisfied with the recommendations made during the contact. A clear majority also reported that the recommendations made by the clinicians affected decisions or treatment regarding the juveniles. Furthermore, the judges/juvenile probation officers overwhelmingly reported believing the program to be beneficial and wanting to see it continue. Ultimately, it can be concluded that the one stakeholder group whose perceptions were meaningfully measured perceived the program very favorably.

### Concluding Comments

Although it is always difficult to discern which findings from a large-scale, multimodal study like this one are the “most important”, we believe that several in particular stand out in terms of their implications, and deserve mention among our concluding comments. One is that mental health and substance abuse problems appear very common among juveniles being detained in Idaho's JDCs. In fact, having one or both type of problem seems to be the norm. This finding clearly provides justification for the continuation of the clinical services program. If the clinical services program (or at least a program like it) does not continue in Idaho's JDCs, it is highly likely that there will be hundreds or thousands of Idaho youth with undiagnosed and untreated mental health and substance abuse problems in the correctional system and in the community. Research from numerous disciplines suggests that when mental illness and/or substance abuse problems are left untreated, there are many social costs—including crime, domestic violence, unemployment or underemployment, overuse of public health programs such as Medicaid, among others; there are also many human costs that are similarly important but more difficult to quantify, including misery and diminished quality of life.

Research from these same disciplines also suggests that prevention and early intervention activities (the latter of which best characterize the clinical services program) can substantially reduce these costs. Thus, to the extent that the clinical services program can help identify and facilitate treatment of mental health and substance abuse problems, it is likely to result in future savings of both social and human costs in Idaho.

A second finding that is important in its implications is that there is an obvious need for effective and accessible mental health and substance abuse services in communities across Idaho. Early detection of mental health and substance abuse problems, and clinicians' recommendations for community-based services to ameliorate them, are only likely to pay dividends if there are effective and accessible organizations or individuals to provide the recommended services. Unfortunately, the low response rate to the parent surveys makes it impossible to know the extent to which barriers to such services might exist, however, it seems reasonable to encourage surveillance to ensure that quality mental health and substance abuse services are available to all juveniles released from JDCs, regardless of where in the state they reside. The results from this evaluation (particularly from our assessment of the most common provisional diagnoses and service recommendations) suggest that these services should include the ability to conduct comprehensive mental health and substance abuse diagnostics, and both individual- and family-based treatments for mood disorders, substance abuse problems, and disruptive behavior disorders. Such services, when utilized effectively, are likely to offer youth who have come into contact with the juvenile justice system an opportunity to avoid deeper enmeshment in it.

A final finding, or perhaps more fairly a realization, is that to develop a clearer picture of the effectiveness and value of the clinical services program, continued refinement in data collection processes is highly desirable. For example, a better system of tracking whether juveniles who have accessed recommended services recidivate to custody at a differential (and hopefully lower) rate than those who do not access such services seems needed. A more successful method for measuring parent awareness of and satisfaction with the clinical services program also appears valuable, as does some mechanism for gathering information on longer-term (i.e., beyond 15 days) recommended service access. In short, based on the data available from this evaluation, the clinical services program is highly effective in helping to diagnose previously undetected mental health and substance abuse problems, ensuring that recommendations for community-based services are provided, and assisting law enforcement personnel in their work with detained juveniles. However, continued and refined surveillance of the program are likely necessary to ensure that it reaches its maximum level of effectiveness.